domain of the general duty nurse has been so eroded from below by nurses' aides and auxiliaries, and from above by nursing specialists that it may often appear that no satisfactory area of service is left to her. Despite this she is responsible for the provision of the great bulk of nursing service but is handicapped in her attempts to improve her qualifications by a too-close identification with the traditional rituals of bedside nursing. An editorial in *Hospital Administration in Canada*[4] puts the case in these terms.

"Present-day organization of nursing does not, for example, give adequate recognition to the clinical specialties. Nurses are not encouraged, sometimes not allowed, to develop special interests in accordance with their aptitudes or apparent talents. They are expected to be able and willing to perform any nursing function anywhere in the hospital. No doubt there is something to be said for this approach up to a certain basic level of nursing. But after a point it becomes merely a convenient administrative measure not at all related to the real demands of patient care."

The common reaction to the difficulties facing the general duty nurse is a flight from the bedside and the wards to specialized forms of nursing service and to positions outside nursing, such as those covered in Morley's term "the frivolities of world travel". When the general duty nurse elects to stay and fight, she may find that the medical staff and other sources of influence in the hospital world are interested chiefly in those nurses with special skills needed in surgical units, recovery rooms, as potential nurse-technicians in cardiac catheterization laboratories, and so on.

Developments which promise to reward the initiative of and give scope to the special talents of the general duty nurse and, at the same time, keep pace with modern trends in nursing service are the Intensive Care and Progressive Care Units described by Edgeworth[5] and others. In these arrangements, nursing service is related to the medical needs of the patient at specific intervals during his illness, and the nursing staff is chosen on the basis of special aptitude and interest in the particular nursing art involved.

Part of the problem of the renaissance of the general duty nurse is the important consideration of the future of "tender loving care" in nursing service. Those who are concerned about the preservation of the best in traditional bedside nursing are right to ask whether nursing must become dehumanized to become efficient. Some additional questions which suggest themselves at once when the overhaul of nursing service is contemplated are: Who will oversee the new division of labour among nurse (general duty), nurse (specialist) and the various semi-trained auxiliaries? Will there still be a place for the young woman who wants to give old-fashioned "nursing care"? Where do the new university-trained nurses fit in? Are these nurses strong on theory and weak in practice?

The responsibility and the necessary authority for nursing reform are distributed at various levels in a complex hierarchy which includes the hospital administrator, the hospital board, the nursing associations, the provincial Hospital Insurance Commissions, and the individual members of hospital medical staffs. In any case, no one of these units in the hierarchy can be expected to make headway unaided.

As befits an ancient and honourable profession, nursing will order its own salvation. However, those in positions of responsibility in the medical profession, in hospital administration, and at various levels of municipal, provincial and federal governments have a duty to keep informed of developments in nursing so as to be able to give assistance, when this is asked for, in an efficient and expeditious manner.

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THE PHARMACY EXAMINING BOARD OF CANADA

ALMOST a century after the first attempt was made to organize Canadian pharmacy a Canada-wide authority has been established, to be known as The Pharmacy Examining Board of Canada. The principal purpose of the Board will be to establish academic qualifications for pharmacists, acceptable to participating provincial licensing bodies.

Royal Assent was given to Bill S-7, "An Act to Incorporate The Pharmacy Examining Board of Canada", in the closing days of 1963. As spelled out in the Act, the purposes of the Board shall be:

(a) to establish qualifications for pharmacists, acceptable to participating licensing bodies;

(b) to provide for fair and equitable examinations, for the issuance of certificates of qualifications to, and for the registration of, applicants therefore; and

(c) to promote, with the consent of the appropriate licensing bodies, the enactment of such provincial legislation as may be necessary or desirable in order to supplement the provisions of this Act.

Attainment of the Board's certificate will be considered an achievement of academic merit. It is anticipated that a certificate issued to a successful candidate may be filed with a participating provincial licensing body for purposes concerned with the securing of registration under the laws of that province.

Participation in The Pharmacy Examining Board of Canada will be on a voluntary basis, and all

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provinces except Quebec have indicated their approval in principle. Le Collège des pharmaciens de la province de Québec opposed passage of Bill S-7 mainly on the grounds that it was unconstitutional and usurped provincial authority.

In this context it is of interest to note, in historical perspective, that all attempts of The Canadian Medical Association to establish uniformity of medical registration throughout Canada foundered on these same rocks and shoals of provincial autonomy for more than 40 years, until Sir Thomas Roddick's magnificent feats of diplomacy and patience were finally rewarded in 1911 by passage of the Bill creating a Dominion Medical Council.

Actually, licensing of pharmacists in Canada is vested in the provincial licensing bodies, and all provincial rights are protected against usurpation by a section in the Act which states that "nothing in this Act shall authorize the Board to interfere with or otherwise affect the rights or privileges of any licensing body under provincial law".

Provision is made for the issuance of a certificate to any pharmacist who holds a provincial licence prior to the date on which the Act came into force. Such a pharmacist is entitled to be registered by the Board without examination after 10 years from the date when he first became so licensed. In other words, a pharmacist who graduated in 1960 can wait until 1970 and can then be issued a certificate by the Board without examination, or, if he chooses, may write the examination as soon as the Board is operative and the first examinations are set. If he passes the examination, he would be issued a certificate. Pharmacists who graduated 10 or more years ago—that is, prior to the Act's coming in force—on application will be issued a certificate by the Board. This latter feature appears to constitute an improvement over the provisions of the Canada Medical Act and seems to be a step toward the reciprocal recognition of provincial qualifications.

Although, in the profession of pharmacy, automatic reciprocity does not exist between all of the provinces in Canada, some provincial licensing bodies do have what might be called an "understanding" with each other. Those provinces which do have a form of reciprocity will benefit by the reduction in the number of procedures and additional examinations to be carried out in their adjudication of applicants for reciprocal licensing.

Composition of the Board will comprise one member appointed by each participating licensing body; two members appointed by the Canadian Conference of Pharmaceutical Faculties, at least one of whom shall be proficient in both French and English; one member appointed by the Canadian Society of Hospital Pharmacists; the President and the General Manager of The Canadian Pharmaceutical Association. Provisional appointments have been made to the first Board and its initial meeting will be convened early in 1964.

RICH AND DETESTED

IN A recent issue of *The Sunday Times* of London (November 17, 1963, p. 15) the writer of an article on the lowly state of the general practitioner in the United Kingdom describes in considerable detail the "deterioration of the prestige of the profession" under the National Health Service. He deplores the excessive demands on the doctor's time in handling trivial complaints, the demands of patients for more and more expensive drugs and the demands on the clinical conscience of overworked and underpaid practitioners.

After this recital of woes the writer remarks almost casually that bad as conditions are for the British general practitioner, at least "He has no desire to be rich and detested as many American doctors seem to be." What a Pharisaical thing to say even if it were true!

The recent perusal of the manuscript of another of the novels of disenchantment with medical life under the N.H.S. left a similar impression. The author, in describing the many missed diagnoses which came to his notice, frequently remarked that this would not likely have happened in the United States where doctors had clinical acumen, a wealth of gadgetry to help them and the objective of dollars to sustain and stimulate their interest. He embellished his end-of-the-bed diagnosis of Graves' disease by noting that in the United States the physician would estimate the value of such a case to be between $500 and $1000.

Although neither of the authors of remarks such as these saw fit to mention Canada in their strictures, it is evident that a distorted view of North American medicine must exist in some quarters in the United Kingdom. Everyone knows that in every trade, profession or calling, regardless of race, colour, country of origin, religion or lack of it, there are rascals and mercenary individuals. But to characterize American doctors as motivated by the pursuit of money is libellous.

It is sobering to ask ourselves "Are we rich and detested?" The answer obviously is that some of us are rich and some of us may be detested but, the Lord be praised, most of us are neither.

A perusal of history and reflection on personal experience will amply confirm the soundness of the maxim, "the broader the generalization, the narrower the mind." In view of this it is hard to understand why well-educated, well-intentioned gentlemen on both sides of the water continue to launch such slashing verbal attacks on each other. If we might presume to offer advice to medical writers and speakers it would be this: North Americans,—don't condemn the N.H.S. as bad medicine, pernicious and socialistic nonsense; residents of the British Isles,—don't be so free with your denunciations of American medicine as mercenary. Neither generalization is accurate, and to utter them does nothing to promote trans-Atlantic amity or the interests of the profession.